

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CERTIFICATION AND LICENSING STANDARDS
REQUEST FOR EXCEPTION

PROVIDER REQUESTING EXCEPTION: _____

DATE: _____

FACILITY TYPE: _____

SIGNATURE OF PROVIDER EXECUTIVE DIRECTOR: _____

NAME OF FACILITY: _____

SIGNATURE OF GOVERNING BOARD CHAIRPERSON: _____

POLICY OR STANDARD
FROM WHICH EXCEPTION
IS REQUESTED (E.G., 000-
00-DD, DDSN RESPITE
STANDARDS, ETC.)

NATURE AND REASON FOR EXCEPTION REQUEST
(SPECIFY IF FOR ONE PERSON (GIVE NAME), ONE
FACILITY (GIVE NAME) FOR ALL RESIDENTIAL
PROGRAMS, DAY ETC., OR FOR THE ENTIRE AGENCY
ALONG WITH THE REASON).

EXPLAIN HOW THE SAFETY OF PROGRAM PARTICIPANT(S), THE STAFF OR THE
PUBLIC WILL NOT BE ENDANGERED, IF THIS EXCEPTION IS GRANTED.

EXPLAIN HOW THIS EXCEPTION, IF GRANTED, THE QUALITY AND QUANTITY OF
SERVICES WILL BE MAINTAINED.

SIGNATURE: _____

DIRECTOR, QUALITY MANAGEMENT

RECOMMENDATION: APPROVED ☐ DENY ☐ DATE _____

COMMENTS :

SIGNATURE: _____

*STATE DIRECTOR

RECOMMENDATION: APPROVED ☐ DENY ☐ DATE _____